ASHCROFT REBUKED ON ASSISTED SUICIDE LAW — PAGE 15

MEHPA Losing Steam PAGE 6

Health Care News

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Bush Backs Federally Mandated Mental Health Insurance Parity

BY CONRAD F. MEIER

President George W. Bush broke ranks with free-market supporters, the small business community, and Republican leaders in the House, endorsing legislation forcing health insurers to treat psychiatric and physical diseases equally.

Critics say the legislation addresses a non-problem, could open the door to massive fraud, and would increase the number of people unable to afford private health insurance.

In a speech delivered April 29 at the University of New Mexico, Bush promised to work with Republican Sen. Pete Domenici of New Mexico, who was at his side. Domenici, whose daughter suffers from mental illness, has long championed federally enforced parity guaranteeing that insurance for mental disorders is as comprehensive as that offered for other illnesses.

"Mental disability is not a scandal," Bush said. "They deserve a health care system that treats their illness with the same urgency as a physical illness."

Mental Health Politics

In 1996 Congress passed "mental health parity"

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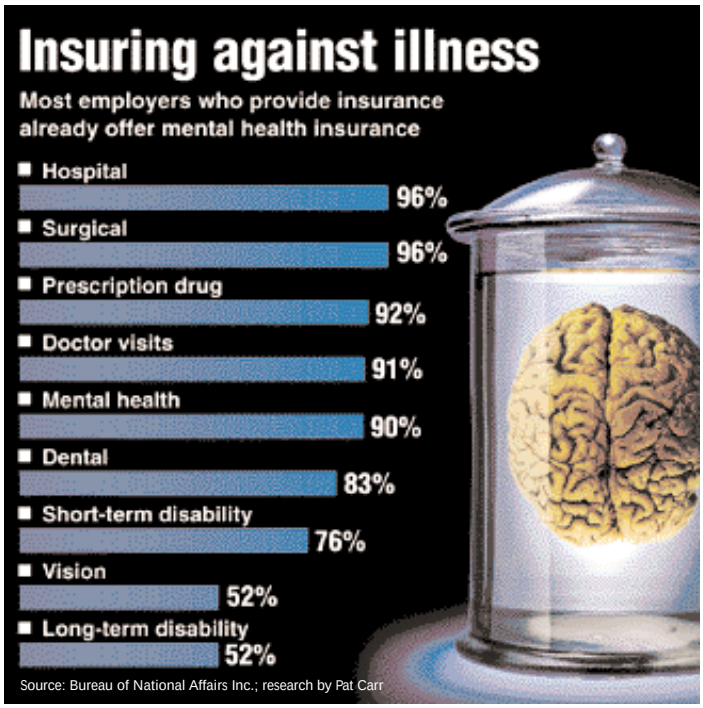

KRT/Paul Trap

Britain's Million-Year Wait

Britain's government-run health care system will force patients now in queues to wait for a combined total of one million years for treatment

BY MATTHEW YOUNG AND EAMONN BUTLER

Britons were shocked recently by newspaper headlines saying there are now a million people on National Health Service (NHS) waiting lists. The figure means one in 60 British citizens are now waiting for medical treatment. Of those who are sick and actually need the NHS to do something for them, one in *six* are condemned to wait.

But the headlines conceal an even more disturbing fact: The enormous length of time people spend waiting for care. We have calculated that adding up the hours, days, weeks, and months Britons spend waiting for care produces an astounding fact: Britons already in the queue for medical treatment will wait a total of *one million years* for care.

How Long?

What patients are most concerned with is not so much the *number* of other people on the waiting list, but the *length of time* they themselves will have to wait. Obviously, in principle it is possible for the waiting list to be small, but for each person to have a long wait; or for the waiting lists to be large, but for each person to

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Real People, Real Coverage

Private insurance market offers coverage to meet needs, budgets

BY LEE TOOMAN

Roughly 15 million Americans who are too young to qualify for Medicare and too affluent to qualify for Medicaid purchase individual (i.e., non-group) health insurance to cover major medical expenses. In the vast majority of cases, these Americans lack access to employer-provided coverage or seek less-expensive alternatives because the cost of that group coverage is so high.

Phony People, Phony Numbers

The Kaiser Family Foundation recently released a study of seven hypothetical people who submitted 420 applications for health insurance coverage to various insurers in the individual insurance market. According to the study:

- 37 percent of all of the applicants, or a family member, were rejected.
- 28 percent had benefit restrictions imposed, 13 percent had premium surcharges, and 12 percent had both.
- 90 percent "were unable to obtain the coverage for which they applied at the standard (premium) rate."

Thus, only 10 percent of the hypothetical people got what the authors of the study might call "real" insurance. Such results, if accurate, would seem to indicate an individual health insurance market unable to meet the needs of most consumers who want to purchase health insurance.

However, the Council for Affordable Health Insurance (CAHI) recently surveyed its member companies that sell policies in

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SEN. EDWARD KENNEDY
D-MASSACHUSETTS
CAPITOL HILL
news watch
http://impressive.net/people/gerald

Kennedy and Clinton Launch Campaign for Government-Run Health Care

BY CONRAD F. MEIER

Sen. Edward Kennedy (D-Massachusetts) plans to introduce new health care legislation that would be cosponsored by Sen. Hillary Clinton (D-New York).

Few details are available from aides to Kennedy and Clinton, who say only that the plan would cut medical costs and provide health coverage for millions of uninsured Americans.

Through a series of proposals, or incremental steps, Kennedy hopes to put national health care "back on the table," nearly 10 years after former President Bill Clinton failed to establish a single-payer health care system for all Americans. The Kennedy-Clinton team is making a bid to reignite the debate over universal health care coverage.

One of the first bills Kennedy-Clinton plan to introduce would require businesses with more than 100 employees to offer their workers health insurance. Employers would be required to pay at least 70 percent of premiums and would be required to provide benefits at least equivalent to those offered through the "standard option" plan of the Federal Employees Health Benefits Program (FEHBP), which is administered by Blue Cross and Blue Shield. Employers would be required to pay the same share of the premium the U.S. government contributes to its employees' health insurance.

Kennedy touched on the employer-mandate legislation in an April 28 speech to a forum on health care and bioterrorism at the John F. Kennedy Library and Museum. The speech addressed a wide range of health care issues and concerns, including the rising cost of premiums, cutbacks in Medicaid because of state budget shortfalls, high administrative costs of processing health care transactions, and deficiencies in medical defenses against bioterrorism.

According to Kennedy's office, the mandate legislation is necessary because uninsured employees working for companies with 100 or more workers account for one-third of all U.S. workers who lack health coverage.

Republicans have waved off similar proposals, and the legislation is not expected to gain much momentum in the Senate, the *Boston Globe* reported.

Still, some health experts say the bill would likely gain more support than the Clinton administration's earlier proposals because it would focus on larger businesses and would not overly burden small companies. "By starting at 100 workers and above, you disarm most of the fierce opposition," said Alan Sager, professor at Boston University's School of Public Health. "You have many smaller businesses—retail, restaurants, small manufacturing firms, small construction—where proprietors felt they would be financially crippled."

Here We Go Again

"We need to begin to lay the groundwork this year for a new effort to enact a program of universal coverage," Kennedy said in his speech. "It is time to put this cause at the top of the national agenda once again."

The Kennedy-Clinton bill may face stiff opposition from a Republican-controlled White House and U.S. House of Representatives. Nevertheless, said Joseph Bast, president of The Heartland Institute and a close observer of the political health care scene, "Republicans need to wake up and recall how the Kennedy-Kassebaum bill, later called the Health Insurance Portability and Accountability Act (HIPAA), slipped right through their fingers, because no one took it seriously."

About 39 million Americans—roughly one in six—do not have health insurance. In Kennedy's home state of Massachusetts there are about 400,000 uninsured people, and about two-thirds of those are working adults, said Marcia Hams, deputy director of Health Care For All, a statewide single-payer advocacy group.

Kennedy's office pointed to recent projections that indicate a looming crisis. During the recession many people lost health insurance along with their jobs. Health insurance premiums nationally rose 11 percent last year and are projected to increase 13 percent next year. As many as 6 million people could lose coverage in 2001 and this year, according to one report.

Many uninsured or underinsured workers have access to insurance through their employers but can't afford their share of the premiums, experts say. A proposal pending in the Massachusetts House of Representatives, aimed at addressing the state's current budget crisis, would lead to the elimination of coverage for 50,000 people, Hams said.

"We're having an expanding crisis for people that are uninsured," Hams warned. "This is not a crisis we can just solve in-state." She added her group would support the Kennedy legislation.

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The PULSE BY GREG SCANDLEN

Free-market health care reform in the news

Health Care A Defining Issue

David Broder is widely considered the "dean of political journalism," so it's no small deal when he writes a column like he did in the *Washington Post* saying, "It is virtually certain that health care will be as big an issue in the 2004 presidential election as it was in 1992." His primary evidence is the announcement that CalPERS premiums are rising 25 percent this year.

Broder concludes, "When the single most important player in the showcase of managed care sees its bills going up at that rate, it says unmistakably that time has run out for the dysfunctional, disjointed thing we call health care."

Broder finds an echo in the person of Dr. Henry Simmons, president of the National Coalition on Health Care, a coalition of some 80 labor, business, provider, and consumer groups. Simmons says in the article, "The incremental strategy is bankrupt. We need a big debate on how to get a grip on this system."

Source: http://www.washingtonpost.com/wpdyn/articles/A63337-2002Apr17.html

CalPERS May Self-insure in the Future

Broder isn't the only person to be alarmed by the CalPERS hikes. Writing in the *San Francisco Chronicle*, Victoria Culliver says CalPERS is dropping two major plans, PacificCare and HealthNet, which will force 150,000 families to change insurers.

This leaves only five plans contracting with CalPERS, down from 14 in 1997, 10 last year, and seven this year. Active workers face an average $52 per month increase in premiums, though some union contracts require the state government to pay most of that.

Medicare HMO members, however, will be paying another $66 a month—a 40 percent increase.

Culliver reports the two dropped plans aren't disappointed, since they were losing money on the CalPERS business anyway. Next, CalPERS will be considering putting everyone in the same self-funded program, eliminating the individual choice element the program has long touted.

Source: http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2002/04/18/BU16464.DTL

Policymakers Should Wake Up to National Problem

The *New York Times* covers much of the same ground in an article by Reed Abelson. Abelson quotes Hewitt's Ken Sperling as saying 25 percent premium increases are common today, and some large employers are getting 100 percent increases. The article says managed care organizations are willing to lose business rather than take a loss by under-pricing their coverage.

CalPERS President William Crist is quoted as saying, "this is a national problem," and Peter Lee, president of the Pacific Group on Health, says, "I don't think policy makers have woken up to how bad things are." The article does not say what these gentlemen would have "policymakers" do to fix this "national problem."

Source: http://www.nytimes.com/2002/04/18/business/18CAR1.html

Consumerism May Be Answer

"Consumerism" may be the answer to these problems, according to Jill Elswick in *Employee Benefit News*.

According to Elswick, Watson Wyatt has discovered that among the large employers they surveyed, "those that adopted various forms of 'consumerism' saw [premium] trend increases of 12.9 percent in 2002, significantly below the median increase of 14.3 percent."

Elswick reports that different businesses are taking different paths to consumerism. Federal Express looked at defined contribution and decided it is "too embryonic in its current state for our culture," but the Pacific Business Group on Health embraced it, "without demanding proof." Peter Lee is quoted as saying, "Our members are willing to accept a good argument."

Meanwhile, back in Washington, the academics remain skeptical. The article says Paul Ginsberg of the Center for Studying Health Systems Change is all for "cost-sharing," but thinks it should take place within an HMO/PPO context.

Source: http://www.benefitnews.com/subscriber/Article.cfm?id=37880643

> **"It is virtually certain that health care will be as big an issue in the 2004 presidential election as it was in 1992."**
>
> **DAVID BRODER**

Managed Care Magazine: "Wow, This Could Work!"

The managing editor of *Managed Care Magazine*, Michael Dalzell, acknowledges that a year ago the magazine "wrote off defined contribution as unworkable. Since then, the landscape has changed."

Dalzell quotes Robert Dawson, president of Empowered Benefits, as saying, "eighteen months ago, there was a lot of confusion about a host of issues—tax consequences, underwriting, risk selection.

"Then, as companies and products addressed those perceived obstacles, employers' reaction was, 'Wow, this can work!' It's a totally different dynamic today."

The article takes a pretty honest look at where the market is heading, balancing some enthusiasm with some skepticism.

Perhaps the most interesting discussion centers on whether old-line insurers or new start-ups are best positioned to take advantage of the trend. The article points out that the established carriers have advantages such as distribution networks and claims systems, but they also "carry the baggage of their old products," which try to "control consumers, not serve them."

Source: http://www.managedcaremag.com/archives/0203/0203.defcon.html

2002 Make-or-Break Year for Self-Directed Care

Meanwhile, Jeannie Mandelker takes a hard financial look at "self-directed" companies in *Investor's Dealers Digest*. She says 2002 will be a "make-or-break year" for these companies, and there is a question whether they can generate enough business before burning through their venture capital.

Mandelker's article is an interesting examination of the financial health of each of the start-up companies, and the specifics of their business plans. It also considers the standing of the old-line insurers who are launching products and the market potential for all these rivals.

Overall it is a pretty optimistic assessment, even though one firm, HealthSync, has already closed. The article says 29 percent of employers "intend to offer some type of self-directed plan this fall for plan year 2003," and quotes one consultant as saying, "I don't have a client out there who isn't looking at this."

Source: The article was in the April 15 edition. Go to http://www.iddmagazine.com/

MSAs Make Inroads in San Antonio

Medical Savings Accounts are still an innovative idea to many employers, according to an article by Aissatou Sidime in the *San Antonio Express-News*.

The article cites a psychologist who recently switched to an MSA because he liked the simplicity and control the plan offered. Another consumer, who has breast cancer, also preferred the MSA even though she hasn't been able to save any money with it. She says, "I had been paying on a PPO before and felt like I was throwing money away."

Source: http://news.mysanantonio.com/story.cfm?xla=saen&xlc=671718

SimpleCare Growing in Washington State

SimpleCare keeps growing to meet the demands of patients and physicians, according to an article in *ManagedHealthcare.info*. The article profiles a 42-member physicians' group that is joining the SimpleCare network to "help offset managed care and Medicare underpayments."

Dr. John Weaver says he loses three dollars for every routine office visit when seeing insured patients, due to cumbersome paperwork and overhead expenses. Under SimpleCare, he can charge patients less and still make more money because of the reduced overhead. One uninsured patient is quoted as saying, "It's less than the cost of a plumber. It's more than fair and I couldn't be happier about it."

The article adds that the challenge is "to get lawmakers to allow families and businesses the chance to build Medical Savings Accounts to allow them to pool money for these kinds of service."

Source: The article appeared on April 22, 2002. Go to: http://www.managedhealthcare.info/, *but you have to be a registered subscriber to access it.*

For more information…

WWW For more information on SimpleCare, see "Fee-for-Service Health Care Makes a Comeback," *Health Care News*, March 2001; "The SimpleCare Story," *Health Care News*, February 2002; and "Oregon Community Adopts SimpleCare Approach," *Health Care News*, April 2002.

Greg Scandlen is senior fellow in health policy at the National Center for Policy Analysis in Dallas, Texas and assistant editor of Health Care News. *To sign up for his free weekly e-newsletter, Scandlen's Health policy Comments, log on to www.ncpa.org/sub. Email Scandlen at GMScan@aol.com.*

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MO Court Limits HMO Ability to Control Costs

HMOs may not charge differential copayments, limit quantity of drugs provided to enrollees

BY PAULA C. OHLIGER, J.D.

There has always been tension among competing interests affected by managed care: for example, those interested in controlling health care costs, and those interested in providing easy access to health care services.

In recent years, increased access to health care services has received the attention of state legislatures, and many states have passed laws to provide greater enrollee access to care, such as access to specialists without referrals from primary care physicians.

In response to constituents' wishes, politicians have passed laws that erode the ability of Managed Care Organizations (MCOs) to accomplish their fundamental purpose: controlling health care costs. Some of those laws have not withstood legal challenge because they were preempted by the Employee Retirement Income Security Act (ERISA).

Other laws, however, have been "saved" from preemption by the "savings clause" under ERISA. Two such laws were challenged in Missouri, and their enforcement was recently affirmed by the U.S. Court of Appeals for the Eighth Circuit.

Missouri Laws

In 1997, Missouri passed two laws affecting how HMOs manage their pharmacy benefits. One law requires HMOs to charge the same copayment for prescription drugs filled by any network pharmacy if the pharmacy meets its HMO contract's explicit product cost determination.

The other law prohibits HMOs from limiting the quantity of drugs an enrollee may obtain at one time, unless the limit applies to all pharmacy providers.

Before the enactment of these laws, an HMO could limit the quantity of a medication an enrollee could obtain from a retail pharmacy to a 30-day supply, while allowing the enrollee to obtain a 90-day supply from a mail-order pharmacy. HMOs could also charge enrollees a higher copayment to fill a prescription at a retail pharmacy than at a mail-order pharmacy. Both of these practices have become commonplace in managed care.

The two laws were challenged by Express Scripts Inc., the Missouri Chamber of Commerce, and the St. Louis Area Business Health Coalition. The parties sued the Missouri Department of Insurance (DOI), arguing that the statutes and related regulations were preempted by ERISA and, therefore, not enforceable.

In other words, the parties wanted HMOs to be able to charge differential copayments depending on which provider filled the prescriptions, and also wanted HMOs to be able to restrict the quantity of drugs an enrollee could receive from certain pharmacy providers.

The Court of Appeals affirmed the lower court's decision that the laws were not preempted by ERISA because of the savings clause. The prohibitions in the statutes are therefore enforceable.

ERISA and the Savings Clause

ERISA challenges are not uncommon these days when laws are passed that affect an employee's health care benefits. ERISA is a federal law that establishes minimum requirements with which employers must comply when offering employee benefit plans.

At the time ERISA was enacted, Congress was mainly concerned with protecting employees from losing their retirement benefits. However, ERISA has had a much wider and unanticipated effect on health care benefit plans offered by employers.

ERISA contains a broad preemption provision. Under this provision, ERISA "supersedes any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." In other words, any state law that "relates to" an employee benefit plan will not be enforceable.

The intent of the preemption provision was to prevent states from interfering with ERISA's intended protection of employees by passing legislation or regulations that were inconsistent with ERISA.

A state law relates to an employee benefit plan "if it has a connection with or a reference to such a plan." A state law does not have to act directly on the plan to be preempted. If the state law indirectly forces the plan administrator to make a particular decision or to take a particular action, it may be found to "relate to" an employee benefit plan.

ERISA also contains what is known as the "savings clause," which prevents certain state laws from being preempted. These laws include, among other things, any law that regulates insurance. The Court of Appeals focused its analysis on whether the two Missouri laws were protected against preemption by the savings clause.

> **"[A]t least for now and at least in Missouri, patient access has trumped measures instituted by HMOs to control pharmacy costs."**

Court's Analysis

Express Scripts argued the Missouri laws did not regulate insurance because HMOs are not in the business of insurance. HMOs provide health care on a prepaid basis, rather than indemnifying their customers, and they are licensed under statutory provisions different from those governing insurance companies.

The DOI countered that HMOs spread and shift risk just like insurance companies do. HMOs, according to the DOI, are "an innovative form" of insurance that are regulated in ways that are similar to insurance companies.

The Court of Appeals agreed with the DOI and held that HMOs are insurers. The court noted HMOs are included in the definition of "insurer" under the state's insurance laws. HMOs and insurance companies are regulated similarly "in degree and substance": They are both supervised by the DOI; they are both subject to minimum standards for customer contracts, financial reporting requirements, maintenance of minimum statutory net worth, periodic examination by the DOI, and use of actuarial analysis to determine health care rates. In the event of financial failure, both HMOs and insurance companies are liquidated or conserved by the DOI.

> **"In response to constituents' wishes, politicians have passed laws that erode the ability of Managed Care Organizations (MCOs) to accomplish their fundamental purpose: controlling health care costs."**

Moreover, HMOs both spread and underwrite risk, just like insurance companies. Thus, the court held, HMOs are insurers for the purpose of this analysis.

Next, the Court of Appeals analyzed whether the statutes regulated the business of insurance. The court looked at certain factors under the McCarren-Ferguson Act, commonly used to determine whether the actions engaged in by an entity are considered the business of insurance.

The court held that the statutes satisfied the McCarren-Ferguson factors: The statutes transferred or spread the risk of higher prescription costs back to the HMOs; they altered an integral part of the policy relationship between the HMO and the enrollee because they required enrollees to be allowed to obtain maintenance prescriptions at retail pharmacies without penalty; and they related only to the insurance industry because they expressly obligated only the HMOs to comply with the requirements of the statutes.

The court held that because the Missouri statutes regulated the business of insurance by satisfying the McCarren-Ferguson factors, the statutes fell within the ERISA savings clause and were not preempted.

Thus, the prohibitions set forth in the statute remain enforceable. According to the court, these statutes benefit enrollees by removing contractual restrictions imposed by the HMOs that impeded timely and convenient access to prescription drugs and to personal contact with local pharmacists. Thus, at least for now and at least in Missouri, patient access has trumped measures instituted by HMOs to control pharmacy costs.

Paula C. Ohliger is a partner in the San Francisco office of Foley & Lardner, the nation's tenth largest law firm, which has a nationally recognized health care practice. This essay was originally published in Drug Benefit Trends, *October 2001 by Cliggott Publishing Co., a division of SCP/Cliggott Communications.*

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Tennessee Doctors Sue HMOs

BY VICKI LANKARGE

Alleging HMOs have created "shell games that avoid their contractual obligations," the Tennessee Medical Association (TMA) is suing Aetna, BlueCross BlueShield of Tennessee, CIGNA, and UnitedHealthcare, charging them with unfair and deceptive business practices.

Several lawsuits were filed April 25, 2002, in Davidson County Chancery Court that allege because of the "extraordinary unequal bargaining positions" between the TMA and HMOs, the TMA's 6,600 members are forced into one-sided contracts that ultimately "impede good medicine."

According to TMA President Dr. David K. Garriott, the association "regrets that we have been forced to go to court to improve the managed care environment that has become unmanageable for so many of our members and patients."

The lawsuits, which seek class-action status, say these unfair business practices include:

- Arbitrarily denying claims for "medically necessary" care without adequate justification or explanation.
- Reducing a physician's payment for medically necessary care by "down-coding"—changing billing codes to indicate a doctor should be paid less. For example, a doctor conducts an extensive office visit with a patient who has a number of health problems but is reimbursed only for a simple office visit that is far shorter and less complicated.
- Bundling claims—issuing a single payment for a group of related medical services, rather than paying for each service individually.
- Improperly reviewing claims by using computerized programs to automatically deny or reduce claims by "down-coding."
- Failing to pay claims on time.

A spokesperson for UnitedHealthcare says the insurer cannot comment because the company has not yet been served with the lawsuit. According to CIGNA, the HMO "makes every effort to pay claims promptly and accurately" on behalf of its plan participants. Aetna officials were "surprised and disappointed" to learn of the lawsuit because the insurer has "a good relationship with doctors in Tennessee."

Telephone calls seeking comment from BlueCross BlueShield of Tennessee were not immediately returned.

New State, Same Charges

Tennessee joins a growing number of states with medical associations that have filed lawsuits to take HMOs to task for secretive business practices the doctors claim are abusive and "allow insurers to avoid their obligation to pay for care provided to patients."

The TMA has retained class-action litigation giant Milberg, Weiss, Bershad, Hynes & Lerach to help local lawyers prepare the case. The attorneys are working with medical associations in Connecticut, South Carolina, and New York that have brought lawsuits against many of the same HMOs and leveled virtually identical charges.

Vicki Lankarge writes for ***Insure.com****, the Consumer Insurance Guide.* ***http:// insure.com***

Florida HMOs Bleeding Money

BY BRENDAN MCKENNA

Florida's health maintenance organizations (HMOs) had a painfully unprofitable year in 2001, losing a total of $52.8 million, according to preliminary figures filed with the Florida Department of Insurance (DOI).

There is one bright spot in the HMOs' fiscal performance: The collective loss of $52.8 million is approximately half the $99.5 million net loss posted by Florida HMOs in 2000.

> **"Florida's health maintenance organizations (HMOs) had a painfully unprofitable year in 2001, losing a total of $52.8 million ... approximately half the $99.5 million net loss posted by Florida HMOs in 2000."**

The financial bleeding of 12 Florida HMOs has forced them to file corrective-action plans with Florida regulators, says Michelle Newell, division director of insurer services for the DOI.

The following 12 HMOs failed to earn an investment return of 2 percent on premiums collected, and thus have been required to detail to the DOI their efforts to achieve that minimum: AvMed Inc., Beacon Health Plan Inc., Capital Health Plan Inc., Florida 1st Health Plans Inc., Foundation Health, a Florida Health Plan, Health Plan Southeast Inc., Mayo Health Plan Inc., The Public Trust of Dade County, Total Health Choice Inc., United Healthcare Plans of Florida Inc., Vista Health Plan Inc., and Well Care HMO Inc.

Seventeen of the 32 HMOs operating in Florida posted a profit for 2001, but with the exception of Humana Medical Plan Inc.—which earned $51 million in net income for the year—net losses far outweighed the gains, according to the HMO Quarterly Summary dated December 31, 2001. The quarterly summary is based on unaudited figures submitted to the DOI by HMOs and is a far less rigorous assessment of their profitability than the annual fiscal reports filed in April, says Newell.

The second-highest earner of the Florida HMOs, America's Health Choice Medical Plans Inc., posted a profit of $7.4 million, followed by Physicians Health Care Plans Inc., which made $7.2 million in 2001.

By contrast, Prudential Health Care Plan Inc. posted a net loss of $31.9 million, United Healthcare lost $29.7 million, Aetna US Healthcare Inc., which bought Prudential Health, was out $20.2 million for the year, and CIGNA HealthCare of Florida Inc. lost $16.7 million.

Two other Florida HMOs, Foundation Health and Vista, posted net losses of more than $10 million, and only two of the remaining nine HMOs that lost money in 2001 lost less than $1 million.

Florida 1st and Vista both required cash injections of $1 million or more to maintain the surplus levels required by Florida law.

Brendan McKenna is a health care writer for ***Insure.com****, the Consumer Insurance Guide.* ***http:// insure.com***

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Grassroots Succeed in Rewriting Minnesota MEHPA

BY TWILA BRASE, RN

Minnesota citizens may soon experience medical martial law. During a declared public health emergency, the proposed Minnesota Emergency Health Powers Act will empower the governor to issue orders without approval from the legislature, and health officials to ration care.

Minnesota's Republican-controlled House and Democrat-dominated Senate passed very different forms of the bill with little debate. A conference committee has met and a final version of the bill is being printed for approval.

The act is Minnesota's version of legislation crafted by the federal Centers for Disease Control and Prevention. The Model State Emergency Health Powers Act (MEHPA), published in October 2001, was distributed to all 50 state legislatures. MEHPA authorizes health officials to commandeer medical supplies, ration health care services, initiate ongoing health surveillance, pressure citizens to comply with medical treatments, and direct the practice of health care professionals.

"In the wake of September 11, the legislation is touted as protection against bioterrorism. But health officials, who began writing the model act well before the terrorist attack, intend to empower themselves all year long."

In the wake of September 11, the legislation is touted as protection against bioterrorism. But health officials, who began writing the model act well before the terrorist attack, intend to empower themselves all year long.

Minnesota Efforts

The battle over empowerment of health officials has been waged between the Minnesota Department of Health and three citizen organizations: Citizens' Council on Health Care (CCHC), the Minnesota Family Council, and the Minnesota Natural Health Legal Reform Project. Professional medical associations have been virtually silent, concerned only that they be held harmless in a court of law if harm or death should occur as a result of following state orders.

The Department of Health is serious about winning. The state's Commissioner of Health has personally testified at every hearing on the bills. Nevertheless, the citizen organizations had a dramatic impact on the bills as they wended their way through committees.

The House bill passed from committee to committee without recommendation. The original 44-page model bill was cut down to 11 pages in the House and 9 in the Senate. Requirements that health professionals provide and citizens submit to medical examinations, vaccination, and treatment were deleted. Preferential access to medical care for state officials and health care practitioners was eliminated.

The governor's authority to delegate powers to an unnamed, unelected person was stripped from the bills. When the bills reached floor debate, the text was amended to affirm a citizen's right to refuse vaccination, examination, treatment, and testing. However, neither bill requires that citizens be *informed* of the right, and health officials can place non-compliant individuals into quarantine.

Citizen Input Prohibited

Despite—or perhaps because of—their previous successes, citizens have not been allowed to participate in the conference committee effort to merge the House and Senate versions of the bill. The chair of the committee, bill author Richard Mulder (R-Ivanhoe), announced at the first meeting that no public testimony would be taken. Concerned, Rep. Lynda Boudreau (R-Faribault), who was not a conferee, came to the second hearing and made a public pronouncement that public testimony should be taken.

Only one citizen had an opportunity to testify before the hearing was adjourned. At the conference committee's third and final hearing, Mulder again announced no public testimony would be

MEHPA continued on page 15

Missouri Legislators Scale Back Health Powers Act

BY CONRAD F. MEIER

In wide-ranging, give-and-take floor debates, Missouri legislators have scaled back the Model Emergency Health Powers Act (MEHPA), a broad anti-terrorism bill the Senate approved in February. As adopted then, the bill would have given sweeping new emergency powers to the governor and would have blocked access to some public records, including the records of City Utilities (CU) of Springfield.

Drafted in reaction to the September 11 terrorist attack, the bill would allow the governor to declare a state of emergency if he had evidence of a biological attack or other disaster. That declaration would then allow emergency licensing of health care professionals from other states, and quarantining citizens who refuse to be immunized if required by a public health official.

Critics in Missouri and across the country assailed the legislation as an affront to civil liberties, and government watchdog groups have complained it would let local governments and municipal utilities close public records by claiming they were security-related.

Effective opposition to the bill came from Republican Senators Sarah Steelman, John Cauthorn, John Loudon, Peter Kinder, and Larry Rohrbach along with Democrats John Schneider and Ted House. These senators presented arguments against what was termed "an extremely poorly constructed bill" and described as " repugnant to the most basic principles of our fair land." Since the bill had been "perfected" and could not be amended, all these senators could do is expose the problems of the bill.

As each flaw in the bill was pointed out in floor debate, the sponsor, Republican Senator Marvin Singleton, would acquiesce and agree to try to work with the house to amend the flaws out of his own legislation, but he would not withdraw the bill.

Singleton has taken out language that would have let utilities like City Utilities (CU) close records of value to potential competitors. CU had lobbied to draft the language to the bill, but some lawmakers protested the measure was too wide in scope.

The version heard in a House committee would allow the closing of meetings or records related to "certain terrorism readiness issues." But local governments or public utilities couldn't close records related to the cost of security measures.

"It really wasn't the intent of the public health legislation to start expanding it to municipal utilities," Singleton said. "The legislative intent was to protect security measures."

Singleton said some groups such as the Missouri Press Association were asked to draft an alternate version of the part related to the state's Sunshine Law, and that he would drop the entire provision of the bill if it meant saving the legislation.

"Missouri legislators have scaled back the Model Emergency Health Powers Act (MEHPA), a broad anti-terrorism bill the Senate approved in February."

Singleton also deleted the quarantine requirement from the bill.

The bill would have required pharmacists to report unusual or increased prescription trends within 24 hours of noticing them. A change made by Singleton is intended to prevent individuals from being identified in the process, he said.

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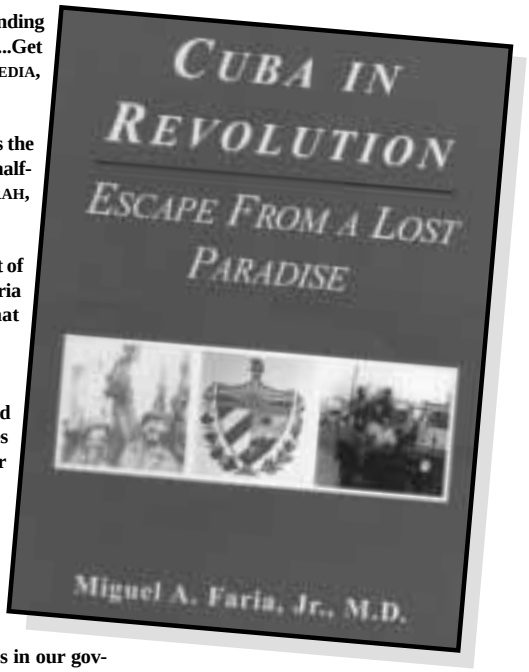

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Court Allows Social Security Disability Rules to Stand

President Dwight D. Eisenhower signed into law the 1954 Amendments to the Social Security Act while on vacation at Byers Peak Ranch near Fraser, Colorado—September , 1954. Photo: SSA History Archives

Complex rules set in 1954 give disabled few choices, perverse incentives

BY DEWEY CREPEAU

On March 27, the U.S. Supreme Court refused to second-guess the Social Security Administration, deferring to the agency's authority to work out the details for implementing and applying its disability rules.

"The statute's complexity, the vast number of claims it engenders, and the consequent need for agency expertise and administrative experience lead the Court to read the statute as delegating to the Agency considerable authority to fill in matters of detail related to its administration," wrote Justice Stephen Breyer for the majority. The Court reached unanimity in two of three parts of the decision; on the third, Justice Antonin Scalia filed a separate opinion concurring in part and concurring in the judgment.

It may be up to Congress—on whose power to tax all Social Security funding depends—to clarify the rules.

Twelve Months ... or Not?

Since the 1950s, the disability component of Social Security has paid formerly employed people who become unable to work. In order to get disability coverage, an applicant must be "...unable to do any type of substantial gainful employment for 12 months ..." or longer.

Litigation over Social Security disability coverage usually revolves around the claimant's ability to engage in "any" gainful activity. But the matter recently decided by the Court involved an interpretation of the 12-month requirement.

In *Barnhart v. Walton*, 235 F.3d 184, Cleveland B. Walton claimed he was disabled by a serious mental illness involving both schizophrenia and depression. The illness caused him to lose his job as a full-time teacher. But he began to work again part time as a cashier before the completion of 12 months of disability; within 11 months of losing his teaching position, he was working as a cashier full time and earning an income that under the Social Security regulations constituted gainful employment.

At first blush, the 12-month requirement would seem to prohibit Walton's receipt of disability payments. However, Social Security rules actually prohibit disability payments only during the first five months of disability. If a claimant can convince Social Security he will be disabled and unable to work for longer than the full 12 months, his payments can start ... even if only six of those 12 months have run.

Trial Work Period

Adding complexity to the matter, the Social Security Administration (SSA) recognizes there is merit in encouraging the disabled to return to work. Thus, a person may be found to be disabled before the 12 months have run, may begin to draw benefits, and then may continue to receive those benefits even if he or she finds work. Social Security refers to this as a "trial work period."

> **"The [Social Security] Act could be amended to provide for more choice and options for the person who is supposed to be protected by law: the disabled employee."**

A trial work period allows the claimant to cash a disability check and a paycheck at the same time, at least for a while. Other components of the trial work period are similarly designed to encourage the disabled to attempt to return to the workforce.

The Social Security Administration had concluded that Walton's mental illness had prevented him from engaging in any significant work for 11 months. Because the statute demanded an "inability to engage in any substantial gainful activity" for 12, not 11, months, SSA determined Walton was not entitled to benefits. He sued, and the District Court affirmed SSA's decision. Walton appealed to the Court of Appeals for the Fourth Circuit, which ruled in his favor, reversing the lower court. In turn, the Supreme Court reversed the Court of Appeals, determining SSA had the authority to interpret its rules and regulations.

Complexity Rules

Barnhart v. Walton makes readily apparent the potential for inconsistency in the SSA's application of its disability rules.

Consider, for example, Claimant A, who applied to SSA for disability payments and received a favorable decision in his sixth month of disability. If he became gainfully employed in his 11th month of disability, he could take advantage of the trial work period, allowing him to receive a paycheck without losing his disability benefits.

Claimant B, by contrast—in the same health, employment, and disability position as Claimant A—might not receive a final decision on her disability claim until the 14th month of disability. This is not an uncommon occurrence. Unlike Claimant A, Claimant B would lose her claim entirely if she became employed in the 11th month of her disability.

A Social Security disability claimant considering returning to work near the end of the 12-month period will be sorely tempted to wait until SSA issues its decision, or at least until after the 12-month period has expired. This hardly qualifies as an effort to encourage the disabled to return to work.

One Size Does Not Fit All

The SSA rules on disability are merely administrative interpretations of the Social Security Act passed by Congress—the statute that legally authorizes payment of disability insurance benefits and Supplemental Security Income to individuals with disabilities. Congress has the authority to amend the Act, and has done so many times since the Act was passed in 1935.

Adopted in 1954 as part of extensive amendments to the Act, the disability component exemplifies that era's post-war, "one-size-fits-all" mentality of government-mandated and -funded retirement and disability plans. The Act's disability coverage may have been as good as it could get in the 1950s.

Much has changed since then. The Act could be amended to provide for more choice and options for the person who is supposed to be protected by law: the disabled employee. Modifications of the law could allow for better coverage at a lower overall cost, which would benefit all of us.

If Cleveland Walton had a choice, he might have been willing to seek out private insurance and pay for a plan defining disability as commencing in the third month, or the sixth, or even the 10th. Given freedom of choice, he might have preferred a plan that didn't pay until the 24th month of disability. Or, knowing his personal health history and that of his family, Walton might have preferred to sink a disability premium into extra life insurance or nursing home protection.

The status quo isn't fair, as Cleveland Walton discovered. It can't be fair. The U.S. is simply too large and its population too diverse to expect a disability plan mandated by Washington, DC to work for everyone, everywhere, all the time.

Dewey L. Crepeau, a private practice attorney in Columbia, Missouri, focuses on workers' compensation and Social Security Disability. He is a former assistant prosecuting attorney. A contributing editor to Health Care News, Crepeau can be reached at dcrepeau@socket.net.

For more information...

WWW The full text of the U.S. Supreme Court's decision in *Barnhart v. Wilson* is available on the Internet at **http://supct.law.cornell.edu/supct/html/00-1937.ZS.html**.

A history of Social Security is available on the Internet at **http://www.ssa.gov/history/history6.html**.

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be seen very quickly.

The National Plan for the NHS, published in 2000, states that by 2005 "no one will wait more than 13 weeks for an appointment and 6 months for admission."

That was two years ago, but the position has worsened slightly since then. The slide in performance suggests that, however determined the policy objectives might be, today's centralized control structure cannot deliver even these modest goals.

In-patient waiting lists. Most urgent cases are seen quite quickly. Consider in-patient waiting times: the period between a consultation with a senior doctor and admission for treatment. There are roughly 10 million admissions for in-patient treatment each year. Just under half (4.3 million, in England) are emergencies and are treated quickly. Just over half (5.7 million) are for other sorts of treatment.

Taking only the figures for England, for the one million people on this waiting list at any moment, it is estimated 155,000 are seen within four weeks.

However, non-urgent cases can have very long waits indeed. Of the remaining 845,000 who are seen after four weeks:

- 345,000 are seen before 13 weeks, but
- 500,000 are not seen until after 13 weeks, and of those
- 250,000 are not seen until after 26 weeks.

Out-patient attendance. There are roughly 44 million out-patient attendances each year. These are people waiting to see a consultant. The biggest delays are in getting to see the consultant in the first place: Once you have had a first consultation, subsequent attendances tend to follow more quickly.

"The National Plan for the NHS, published in 2000, states that by 2005 'no one will wait more than 13 weeks for an appointment and 6 months for admission.'"

Of the (roughly) 11 million first attendances with a consultant:

- 8.4 million (78 percent) are seen within 13 weeks, of whom:
- 3.8 million (35 percent) are seen within four weeks; but
- 2.4 million (22 percent) are not seen until after 13 weeks.

How Much Time Wasted?

Of course, we can probably never entirely get rid of waiting time in any service, in health care or even at the supermarket checkout. But for the population as a whole, today's NHS waiting lists add up to a very long wait indeed. As Professor Richard Feachem showed in the January 19, 2002 issue of the *British Medical Journal*, NHS waiting times compare very unfavourably with waiting times in Kaiser Permanente, a California health plan whose spending per patient is remarkably close to that of the NHS. In Kaiser, 90 percent of in-patients are treated within 13 weeks, and 80 percent of out-patients are seen within two weeks.

But let us set a more modest target for the NHS and say merely that a wait of over four weeks is unsatisfactory. Given the pain and anxiety people may suffer, a wait of that length clearly must be unsatisfactory. So how much time do NHS patients spend in this "clearly unsatisfactory" state of waiting more than four weeks?

Let us also assume people reach the top of the waiting lists at a fairly regular rate as indicated by our raw statistics, so that all out-patients are seen within 20 weeks and all in-patients are treated within 36 weeks. (Though as a number of hip-replacement patients will testify, this is perhaps an over-generous assumption.) We can then calculate that, in rough terms:

"Undoubtedly, this strategy [rationing demand by waiting lists] has some success. ... A quarter of cardiac patients actually die before it is their turn to be called in, which reduces the burden of demand even more."

- The in-patients on the NHS waiting list will spend 235,000 years waiting in excess of four weeks for their treatments; and
- NHS out-patients will wait 830,000 years waiting beyond four weeks to be seen.

That is a total of 1,065,000 years of unsatisfactorily long waiting.

At What Cost?

Of course, this is not the whole story. Waiting lists cost people a lot more than just time. Dudley Lusted, chief economist at PPP Healthcare, undertook a major exercise on the economic cost of waiting lists. His starting point was to estimate the cost to employers of working days lost—counting the period after the first four weeks' absence—where the individual remained too incapacitated to return to work and was awaiting medical treatment.

Averaged across the workforce, Lusted estimated two days lost per employee per year. With a workforce of about 22 million, that suggests 44 million work days lost due to delays in medical treatment. With a weighted average pay of £15,000, the cost is therefore £660,000,000.

The cost of anxiety and limitations on activity for the patients themselves has been estimated by Professor Carole Propper of Bristol University. Taking this at £5 a day (the mid-point of her estimated range), the unseen cost of the 1,065,000 years that people spend waiting beyond four weeks is approximately £19.4 billion.

There are, of course, other costs too. A MEDIX survey identified the extra burdens on general practitioners and their patients. Among the key results were:

- Worsening conditions: 66 percent of GPs had patients waiting as out-patients admitted as emergency because their condition worsened.
- Increased burden: 90 percent of GPs had patient consultations arising out of waiting list

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delays, and 70 percent of GPs dealt with problems arising from that—an estimated 1.5 million extra consultations.

Why the Wait?

Waiting lists are the inevitable consequence of a politically driven, tax-funded, centrally run health service. Users have no customer power over the system. Since the amount people pay (through taxation) is unrelated to the volume of services they use, they have every incentive to demand as much service as they can get, however marginal or even unnecessary. And because—unlike almost all other goods and services—there is no price mechanism to inhibit the over-demand, the central authorities must resort to the only other strategy open to them, that of rationing.

> "Waiting lists are the inevitable consequence of a politically driven, tax-funded, centrally run health service."

Waiting lists are merely the symptom of this. They represent unmet demand. They are rationing by queuing.

Undoubtedly, this strategy has some success. Some people do not bother to see the doctor because they cannot face a long wait, while others fail to turn up at consultants' appointments because they have simply got fed up waiting. A growing number choose to dip into their own savings and pay directly for their treatment in the private sector. A quarter of cardiac patients actually die before it is their turn to be called in, which reduces the burden of demand even more.

What Should Be Done?

Although all these costs are necessarily estimates, it is clear the cost of NHS waiting lists—in terms of anxiety, incapacity, time off work, the cost of absence to employers, the extra costs to the NHS of patients whose condition worsens, and the cost to GPs of seeing patients who are waiting for treatment—is well over £20 billion.

But rough as they are, these calculations do tell us something about the real human scale of the waiting lists and the costs to individuals and the economy. Unfortunately, fewer people are being put on the waiting list, fewer of those are being treated in good time, and the total queue is not getting any shorter. Clearly, productivity is falling, despite a real increase in NHS funding of about £5,000 million in the past two years. The inescapable conclusion is that the current structure simply cannot make the improvements we all want, and that radical reform is inevitable.

> "Pumping more money into a failing structure will not deliver the benefits. Importing clinicians or exporting patients is a marginal stop-gap. We need to change the system."

Pumping more money into a failing structure will not deliver the benefits. Importing clinicians or exporting patients is a marginal stop-gap. We need to change the system.

Most health care can be delivered locally, and there is a strong case for managing that delivery locally too.

More local management, greater diversity of provision, and methods to make the financial rewards come upward from the patient, rather than downwards from Whitehall and through the health bureaucracy, could all produce a more patient-centered system where there was a real downward pressure on waiting times both from patients and providers.

Dr. Eamonn Butler is director of the Adam Smith Institute, a highly respected think-tank in London, England. Matthew Young, also with the Adam Smith Institute, was formerly head of office automation policy at the Central Computer & Telecommunications Agency, head of policy branch on civil service running costs, a press secretary at 10 Downing Street, and private secretary to the head of the civil service. They can be contacted by email at info@adamsmith.org.uk; by mail at 23 Great Smith Street, London SW1P 3BL.

For more information…

WWW on Britain's National Health Service, see Conrad F. Meier's series for *Health Care News*, "Health Care in England: Not Your Cup of Tea." The series ran in the September and December 2001, and the March, April, and May 2002 issues. All are available on The Heartland Institute's Web site at **www.heartland.org**.

Image courtesy tinyburtoncollective.com

Health Care Fight Returns

BY JOHN HOOD

The health care reform debate of the early 1990s didn't end with the defeat of HillaryCare in 1993. It just went underground.

Those looking to expand the reach of federal and state government into medicine merely changed their tactics and started advancing their agenda in smaller, more digestible bites. Meanwhile, conservatives who opposed President Bill Clinton's wacky plan began to lose interest. They failed to fight for market-based policies, such as tax reform, that would increase consumer power and responsibility.

Backlash

The result has been disastrous. After a brief period of quiescence in the mid-1990s, health care inflation is back with a vengeance. Much of the new inflation can be attributed to such liberal legislation as the 1996 Kassebaum-Kennedy bill, the deceptive Child Health Insurance Program adopted in 1997, and various regulatory schemes that I have called the "Trial Lawyers' Bill of Wrongs."

> "If automobile insurance covered not just emergencies and accidents but oil changes and wiper blades, motorists would probably change their oil and blades more often, even though it wasn't necessary."

In the public sector, the resurgence of rapid growth in annual health care expenditures is a major reason the federal budget slipped back into deficit, and why so many state governments are seeing big budget gaps of their own.

In my home state of North Carolina, for example, Medicaid expenses will grow by an astounding $1 billion or so over two years. (Counties are also suffering from this, because in North Carolina they are forced to pay about 5 percent of the cost but have no real control over prices or services.) The state employee health plan is similarly imperiled, requiring hundreds of millions of dollars over two years just to remain solvent.

The pressure is also severe in the "private" sector, which I put in quotes because our current employer-based health insurance system is a creation of government rather than free markets. According to a recent story in *Investor's Business Daily*, health plan costs for private-sector employees rose 8.1 percent in 2000 and 12.2 percent in 2001, and are projected to increase 13.6 percent in 2002. The cost of supplemental health plans for retirees is growing even faster, with a 15.1 percent rise projected for this year alone.

It's the Regulation

Admittedly, health care expenditures in a developed country probably *should* grow somewhat faster than the rest of the economy. As people become more prosperous, they often spend a smaller share of their disposable income on food and other goods and a higher percentage on such services as recreation, travel, and health care. The aging of a population will also have the effect of shifting consumption patterns toward health care.

But the current increases don't reflect mere demographic realities. They reflect a lack of incentives for efficiency. The principle is simple. Most employees at a business lunch where their employer pays the bill are tempted to order more expensive fare than they would if they were paying the bill directly. If automobile insurance covered not just emergencies and accidents but oil changes and wiper blades, motorists would probably change their oil and blades more often, even though it wasn't necessary.

You can't expect insurance products—originally designed to help individuals manage the risk of a major calamity—to pay for such routine services as doctor visits and prescription drugs. That doesn't make sense. It weakens the relationship between prices paid and services demanded, encouraging consumers to consume medical services inefficiently because they aren't paying a significant portion of the bill at the time of sale (and, in the case of Medicaid, they aren't paying any part of the bill in the first place).

> "[A]dvocates of ... socialized health insurance ... knew exactly what they were doing when they lobbied for Medicaid expansions and new insurance regulations while fighting off tax reforms and medical savings accounts."

The system is broken—which is exactly what advocates of a single-payer system, otherwise known as socialized health insurance, prefer. They knew exactly what they were doing when they lobbied for Medicaid expansions and new insurance regulations while fighting off tax reforms and medical savings accounts. Let's see how long it takes for them to proclaim that the free market has failed and it's time for the government to take over.

The real problem is that a free market for health care—one not warped by regulations and special tax advantages—doesn't exist.

John Hood is president of the John Locke Foundation and publisher of Carolina Journal.

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MENTAL HEALTH continued from page 1

legislation requiring employers who had more than 50 employees and who included mental health coverage in their insurance benefits mix to offer the same annual and lifetime benefits for mental health care as for standard health care, such as surgery and physician visits. The law went into effect in 1998 and expired last year.

Many mental health advocates believe the Mental Health Parity Act of 1996 did not work as intended. They support more comprehensive mental health parity legislation.

Merrill Matthews, director of the Council for Affordable Health Insurance, explained, "One reason for the Mental Health Parity Act's limited impact is that it contains a provision exempting employers for whom compliance would increase health care expenses by more than 1 percent.

"In addition, proponents believe many employers are escaping by imposing limits not specifically addressed in the law. For example, under the law employers can still hold down costs by limiting the number of inpatient or outpatient care days and by imposing higher co-payments for mental health services. Finally, employers with 50 or fewer employees are exempted from the legislation."

A Non-Problem?

Many health insurance experts say coverage of mental diseases is already sufficiently widespread and oppose imposition of another expensive mandate on employers. Karen Ignani, president and chief executive officer of the American Association of Health Plans, was quoted by the Associated Press as saying, "With so much at stake, it is more important than ever to use diligence and discretion when it comes to adding costly new mandates to an already overburdened system."

Ninety percent of employers cover significant mental conditions that cause functional impairment, said a representative of the Health Insurance Association of America (HIAA).

According to a 1998 employer survey published in the journal *Health Affairs*, 91 percent of small firms (10-499 employees) and 99 percent of large firms offer mental health and substance abuse coverage in their most-used medical plans. Mental health and substance abuse coverage was included in 87 percent of indemnity plans, 88 percent of HMOs, 97 percent of Point of Service (POS) plans, and 93 percent of Preferred Provider Organizations (PPOs).

Small business groups exempt from the Mental Health Parity Act come under state law rather than federal law. Most states have a mental health mandate of some sort.

HIAA has warned that a broad mandate for parity would amount to a "hidden tax on businesses and workers." Advocates of mental health parity, however, think coverage would cost less in the end because the mentally ill would be able to get the full range of treatment they need to resume fully productive lives.

Open Door to Fraud

Matthews questions whether another mental health parity mandate would be good for patients, the uninsured, and the mental health industry.

"While it could help some patients," says Matthews, "it would drive up the cost of health insurance and force more people into the ranks of the uninsured." He also notes mental health care has been subject to widespread abuse over the years, causing state and federal officials to exclude or close down a number of mental health facilities. "So before acting," suggested Matthews, "Congress needs to consider whether new mental health parity legislation would do more harm than good."

The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), knew someone was up to no good as far back as 1997. The average yearly cost for each senior citizen receiving mental health services had jumped from $1,642 in 1993 to more than $10,000 by 1997. Former Medicare administrator Nancy-Ann DeParle contended at the time that 90 percent of the patients had no mental illness serious enough to qualify for special treatment. "You walk into these places and people are playing bingo and eating lunch," DeParle said.

No Free Lunch

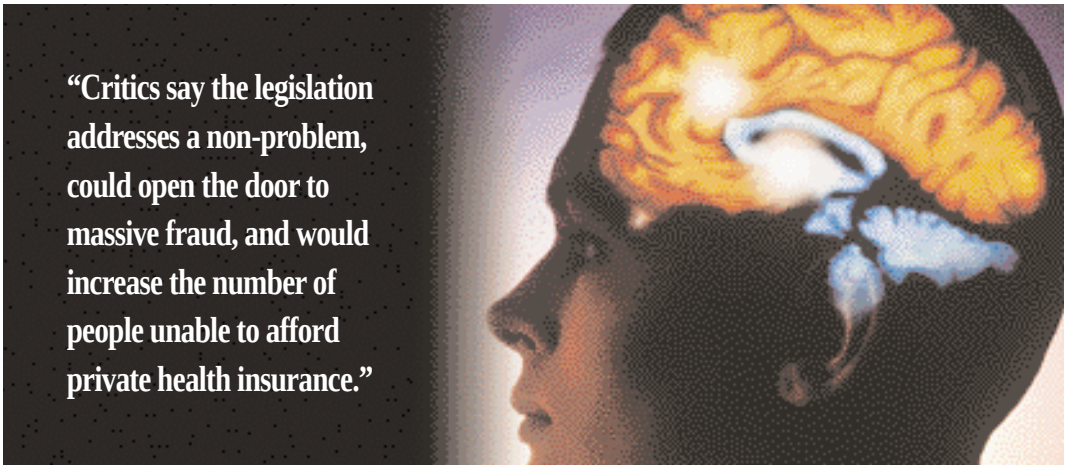
A 1998 study sponsored by the National Advisory Mental Health Council (NAMHC) Parity Workgroup, a division of the federal National Institute of Mental Health, estimated mental health parity would add less than 1 percent to the cost of a health insurance policy for an HMO.

A 1998 study by Mathematica Policy Research Inc. estimated a 3.6 percent price increase across all plans, with a range of 0.6 percent increase for HMOs up to 5 percent for fee-for-service plans.

A 1997 analysis by the actuarial firm Milliman & Robertson for the National Center for Policy Analysis, examining the cost of a typical mental health mandate (not specific legislation), concluded mental health parity legislation tends to drive up costs by 5 to 10 percent.

According to the Congressional Budget Office (CBO), for every 1 percent increase in insurance costs, the number of uninsured increases by 200,000 people. This means a new national mental health insurance mandate could cause between one million and two million people to lose their health insurance.

Matthews suggests Congress and state legislatures can override insurers' limits, but that action comes at a price: more expensive health insurance, more uninsured, and more opportunities for abuse. Until a mechanism is found to balance the need for mental health services and the potential for abuse, it may be best to let insurers themselves decide how much to cover.


"Critics say the legislation addresses a non-problem, could open the door to massive fraud, and would increase the number of people unable to afford private health insurance."

For more information…

WWW See the full text of Merrill Matthews' *Policy Brief* for the National Center for Policy Analysis, "Do We Need Mental Health Parity," at **http://www.ncpa.org/ba/ba297.html**.

Other resources on the Internet include the National Association for the Mentally Ill, **http://www.nami.org**; the American Association of Health Plans, **http://www.aahp.org**; the National Mental Health Association, **http://www.nmha.org**; and the Health Insurance Association of America, **http://www.hiaa.org**.

"Ninety percent of employers cover significant mental conditions that cause functional impairment, said a representative of the Health Insurance Association of America."

Looking for an outstanding speaker?

Who is Dr. Merrill Matthews?

Merrill Matthews Jr., Ph.D., is a Heartland Senior Fellow specializing in health care policy and a visiting scholar with the Institute for Policy Innovation. Dr. Matthews is past president of the Health Economics Roundtable for the National Association for Business Economics, the largest trade association of business economists, and health policy advisor to the American Legislative Exchange Council, a bipartisan association of state legislators.

Engagements are scheduled on a "first come, first served" basis, so call 312/377-4000 today to schedule Dr. Merrill Matthews to keynote your next event!

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Cal. Parity Law Has Little Effect on Premiums or Coverage

BY DIANE CAROL BAST

A new report from Mathematica Policy Research Inc. concludes implementation of California's mental health parity law has had, to date, no ill effect on health insurance in the state. The researchers noted, however, that their results are preliminary, and that "the full impact of parity may not be known for several years."

California passed its parity law in 1999 to improve access to and the quality of mental health services in the state. The law, which requires private health insurance plans to provide equal coverage for physical health and selected mental health conditions, also attempts to end discriminatory practices in health insurance and reduce the stigma associated with mental illness.

In "A Snapshot of the Implementation of California's Mental Health Parity Law," researchers Timothy Lake, Alicia Sasser, Cheryl Young, and Brian Quinn conclude, "... mental health benefits have been expanded to conform with the parity mandate, but it will take time and additional effort to address such goals as reducing stigma and improving access to care for people with mental illness. ... [T]here is a broad consensus that the full impact of parity may not be known for several years, until consumers become more aware of the expanded benefits."

Study Interviews Stakeholders

The report, written in February 2002 and formally released in April, is the first comprehensive look at the law's impact, one year after its implementation. The Mathematica researchers interviewed more than 60 individuals representing more than three dozen organizations at the state and local levels, including representatives from state and county governments, health plans, providers, employers, and consumer advocates.

Those stakeholders reported premiums did not increase substantially in the first year, as some had feared they would. Moreover, employers did not drop coverage or switch to self-insured plans in order to avoid the law's mandate.

Although most aspects of implementation went smoothly, Lake and his colleagues noted the following challenges:

- Some consumers experienced disruption in care as a result of some health plans' transition to managed behavioral health organizations in response to the law.
- The implementation of parity only for selected conditions, rather than for all mental health diagnoses, created administrative challenges and confusion for some stakeholders.
- Some stakeholders remain uncertain about the extent to which the law will enable or encourage people who have traditionally received treatment from the public sector, such as children with serious emotional disturbances, to obtain care from private providers.
- Consumers were not well informed about the changes, despite communication and education efforts on the part of health plans, providers, state agencies, and others.

"An important goal of the law is to remove discriminatory limits on mental health benefits under private insurance. This goal was achieved during the first year, but much work remains to be done to make parity work well in the future," said Lake, a health researcher at Mathematica and lead author of the report. "Consumers will need more education about the law to achieve goals such as improving access to care and reducing stigma."

Mathematica, a nonpartisan research firm, conducts policy research and surveys for federal and state governments, foundations, and private-sector clients. The California parity study was conducted for the California HealthCare Foundation.

Diane Carol Bast is editor of Health Care News.

For more information...

WWW The Mathematica report, "A Snapshot of the Implementation of California's Mental Health Parity Law," is available on Mathematica's Web site at **www.mathematica-mpr.com/PDFs/redirect.asp?strSite=snapshot.pdf**. For printed copies, contact the group's publications department at 609/275-2350.

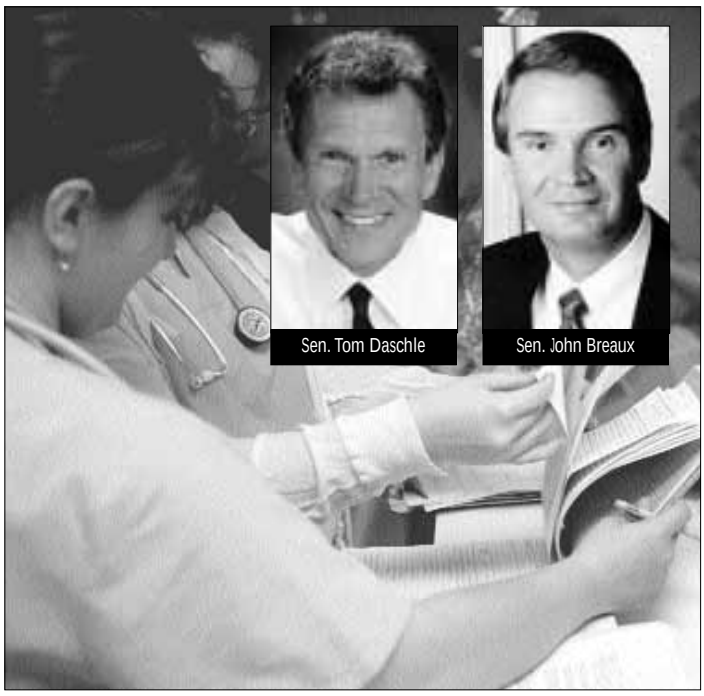
Lead author Timothy Lake can be reached at 617/491-7900, ext. 230; email **tlake@mathematica-mpr.com**.

MSAs Better than COBRA

BY MICHAEL CANNON AND LARRY CRAIG

The U.S. Senate may soon debate Trade Adjustment Assistance (TAA) legislation that would provide health coverage for workers who lose their jobs due to foreign competition.

The best thing Congress can do to preserve displaced workers' health coverage is allow all workers to open a personal, tax-preferred Archer Medical Savings Account (MSA) that can meet their medical needs in the event they lose their job.



Majority Leader Tom Daschle and Senator John Breaux made this point nearly a decade ago, in a September 8, 1992 letter seeking support for their MSA bill:

> Once a Medical Care Savings Account [MSA] is established for an employee, it is fully portable. Money in the account can be used to continue insurance while an employee is between jobs or on strike. ... Any money not spent out of a given year's allowance could be kept by the employee in an account for future medical needs during times of unemployment or for long-term care.

Today, MSAs are available through a limited demonstration program , where they have proven popular. As Breaux and Daschle note, these MSA holders are already protected from a lapse in health coverage while between jobs. Congress should offer all Americans this protection by making MSAs more widely available.

At roughly the same cost, MSAs would offer displaced workers far more assistance than is offered by the leading Democrat proposal (contained in S 1209), which targets only workers who are TAA-eligible. Congressional Budget Office (CBO) estimates suggest the Democrat proposal would cover 75,000 otherwise-uninsured workers at a cost of $1.2 billion over five years.

By contrast, data from the Internal Revenue Service and Office of Management and Budget indicate MSAs could cover more than 380,000 otherwise-uninsured workers for the same amount of money, making MSAs five times more cost-effective. The CBO estimates expanding MSAs to *all* private-sector workers would cost $1.8 billion over five years.

COBRA Less Helpful

The Democrat plan would spend taxpayer dollars to help some TAA-eligible workers buy coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and would encourage states to extend Medicaid coverage to other TAA-eligible workers.

COBRA allows certain workers to keep their coverage after they leave a job. COBRA coverage is expensive—both for workers (who must pay their own share of the premium, plus their employer's share, plus a surcharge) and employers (because COBRA users still consume some 50 percent more than they contribute, a cost that is passed on to employers and remaining employees).

Encouraging more workers to opt for COBRA coverage would impose further costs on employers. Workers would not fare much better, because the Democrat plan helps COBRA-eligible workers only if they stay with their former employer's health plan.

Democrats offer nothing but Medicaid to workers ineligible for COBRA, and absolutely nothing to workers ineligible for TAA.

If Congress is serious about helping displaced workers maintain health coverage, it should immediately make MSAs widely available to all private-sector workers. To choose the Democrat plan instead would be to deny health coverage to over 300,000 Americans.

Michael F. Cannon is domestic policy analyst and Larry E. Craig is chairman for the Republican Policy Committee of the United States Senate. They can be reached by mail at 347 Russell Senate Office Building, Washington, DC 20510; phone 202/224-3463; fax 202/224-1235; email michael_cannon@rpc.senate.gov; Web http://rpc.senate.gov/.

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PRIVATE continued from page 1

the individual market to see what actually happens when real people apply for real coverage—and came up with dramatically different results.

Different People, Different Needs

People who seek private health insurance come from all walks of life. For example:

- Suzy is a young, single mother. She works full time, but her employer cannot afford to provide health insurance.
- Bill and Diane are "empty-nesters" in their late 50s. They worked and saved and have taken early retirement.
- Stanley's employer provides a group health plan but pays only half the employees' cost and contributes nothing toward the cost of dependent coverage. Stanley needs a less-expensive alternative for his wife and children.
- Mary is recently widowed. Although she can get by without working, she wants the security of health coverage.

Each of these people has different health insurance requirements. Younger families with children typically want lower deductibles and copayments because children have frequent minor ailments. Older people without children often prefer high deductibles in order to protect their hard-earned assets from catastrophic medical costs. The private market delivers these and many other options.

Different Insurers, Different Options

Private health insurance in the individual market comes with myriad deductibles, cost sharing, levels of managed care, and benefit options. Such options allow people to match their coverage to their needs and budgets. Consider:

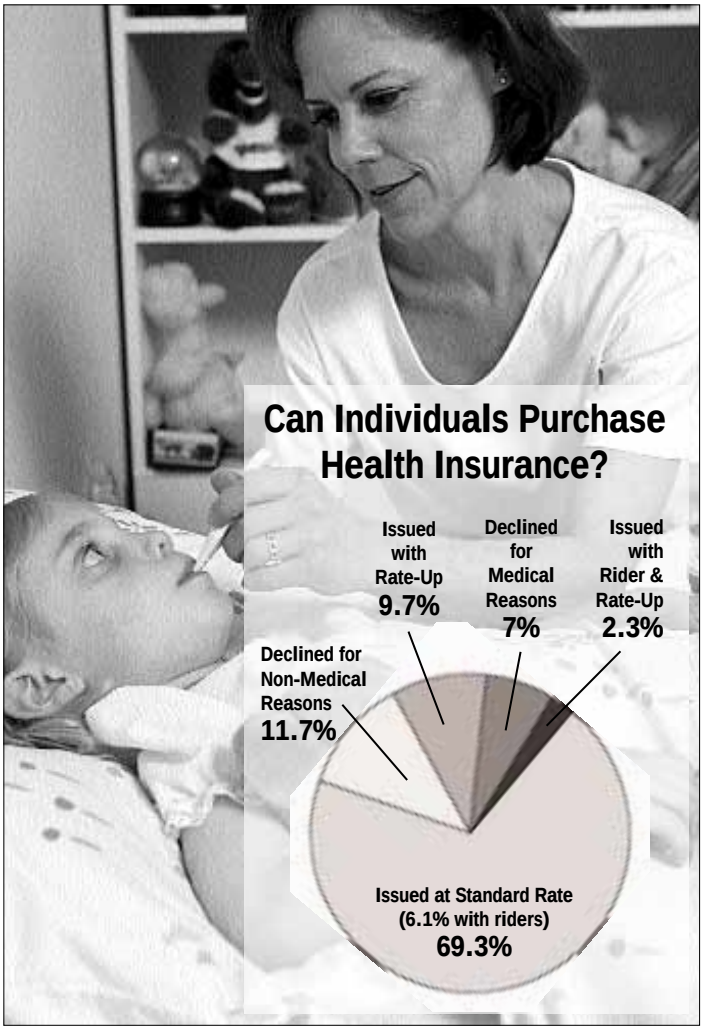
Comprehensive Plans—These are designed for people who want health insurance to cover both their routine medical costs and major health care expenses. Most companies serving the individual market offer several deductible, coinsurance, and managed care options, along with maternity, supplemental accident, and life insurance "riders."

High-Deductible Plans—Annual deductible options range from $1,000 to $5,000 and higher. Applicants can choose among Preferred Provider Organizations (PPOs) or fee-for-service plans. Options include a prescription drug card. People who choose this type of coverage take responsibility for paying routine medical expenses and rely on insurance for major health care costs.

Basic Coverage—This no-frills solution suits people who want to save as much as 40 percent of the cost of typical major medical coverage. These plans cover inpatient and outpatient care for serious illnesses and injuries but lack the "bells and whistles" of comprehensive health insurance.

Medical Savings Accounts—Recent federal legislation created MSAs that allow self-employed workers to deposit money tax-free into an account that can be used for small and routine medical care. The law requires those opening MSAs to purchase a high-deductible policy to pay for major medical expenses.

Given that several insurance companies and HMOs compete vigorously in most markets, those seeking coverage usually can pick and choose from a wide range of options.


Can Individuals Purchase Health Insurance?
Issued with Rate-Up 9.7%
Declined for Medical Reasons 7%
Issued with Rider & Rate-Up 2.3%
Declined for Non-Medical Reasons 11.7%
Issued at Standard Rate (6.1% with riders) 69.3%

Is it Difficult to Get Private Health Insurance?

"[T]he Council for Affordable Health Insurance (CAHI) recently surveyed its member companies that sell policies in the individual market to see what actually happens when real people apply for real coverage ..."

Everyone understands that when people want to purchase a multimillion-dollar life insurance policy, their age, sex, and medical history will be considered. This underwriting is an effort to determine whether to offer the policy and, if so, how much to charge. The same is true for comprehensive health insurance: Lifetime benefits may be several million dollars or even unlimited.

However, it is important to note that different companies underwrite differently. Some may increase the cost of premiums if the applicant has a chronic medical condition. Others will place a rider on the policy and cover the insured for all medical costs except those related to the medical condition. For example:

Increased deductible due to high blood pressure or asthma. A person with these conditions knows that he or she will incur costs to control them, mostly with prescription drugs. The insurance carrier might offer coverage with, say, a $900 deductible instead of the $500 deductible requested. The condition would still be covered. Nothing additional would be limited or excluded.

Outpatient cholesterol treatment. A person being treated with drugs for high cholesterol has a known expense. The insurance carrier might offer such a person coverage that excludes doctor visits, diagnostic tests, and drugs only for the treatment of the high cholesterol. Coverage would otherwise be intact, and if the high cholesterol resulted later in a heart attack or a stroke, treatment for the latter conditions would be covered.

The ability of carriers to offer "rate-ups" and riders can make an enormous difference in the number of people issued coverage. A few years ago, Louisiana passed legislation prohibiting carriers from issuing coverage with medical riders. So many people were rejected for coverage that in 2001 the Louisiana Department of Insurance proposed legislation restoring the carriers' ability to offer coverage with medical riders. The bill, HB 830, passed overwhelmingly and was signed into law by the governor.

Results of the CAHI Survey

As the accompanying figure shows, CAHI's survey of member companies came to a very different conclusion than Kaiser's. According to the CAHI analysis:

- Only 7 percent of the applicants were declined coverage for medical reasons.
- 11.7 percent were declined for nonmedical reasons, such as application through an agent not registered to represent the company or the failure of the applicant to enclose a check with the application.
- 9.7 percent were offered a policy at a higher premium, 6.1 percent were offered policies with riders but standard premiums, and only 2.3 percent had both a premium rate-up and a rider.

In sum, 81.3 percent of applicants received a policy and 69.3 percent got their policies at standard rates.

Are Standard Rates Affordable?

Until recently, no serious survey had been conducted on the cost of private health insurance. But in the summer of 2001, eHealthInsurance, one of the best sources for health insurance quotes for individuals and small businesses, analyzed "the purchasing decision of 20,000 customers from across America who have obtained health insurance for themselves or their families" through its free Internet service.

The results surprised many: Private health insurance often is more affordable than group coverage. The average premium for the purchased policies was only $1,200 to $1,500 per person per year. This is 2.8 to 3.6 percent of the U.S. median household income of $42,148 (2000).

The study reported that "the average premium per-member-per-month for policies sold through eHealthInsurance is 25 percent higher for small business members than for individual members." Apparently, more than 10 years of state and federal "reforms" in the small group market have had a serious negative effect on the cost of small group health insurance.

"Private health insurance in the individual market comes with myriad deductibles, cost sharing, levels of managed care, and benefit options. Such options allow people to match their coverage to their needs and budgets."

Conclusion

The individual market for health insurance is not a theory; it is a reality for millions of Americans. In those states that haven't destroyed the market for health insurance by excessive regulation, working families have numerous options at affordable prices. These aren't hypothetical applicants; they are real people with real coverage.

Lee Tooman is vice president of government affairs for Golden Rule Insurance Company in Lawrenceville, Illinois. His email address is ldtooman@goldenrule.com. *Reprinted with permission from the Council for Affordable Health Insurance, which published this article in May 2002 as part of its* Issues & Answers *series.*

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MEHPA continued from page 6

taken. Boudreau was not present.

The conference committee also did not follow protocol. Rather than limiting debate to the bills that passed in the House and Senate, health officials were allowed to draft two new bills as compromise versions. The resultant conference committee bill is an amalgamation of the four versions.

Constitutional Issues Abound

If the conference committee bill becomes law, the governor and health officials will have new powers, particularly in peacetime. The proposed bill gives the governor authority to issue orders and make rules with the full effect and force of law during peacetime emergencies, related or unrelated to public health. Current Minnesota law provides the governor with that authority only during a national security or energy emergency.

The bill does not limit the police powers of health officials to bioterrorism incidents. A "public health emergency" can be declared on the mere *belief* that an illness or health condition in Minnesota is caused by a whole list of items, only one of which is bioterrorism. No actual incident is required. The appearance of a new or previously

"Despite—or perhaps because of—their previous successes, citizens have not been allowed to participate in the conference committee effort to merge the House and Senate versions of the bill."

controlled communicable disease is included on the list, meaning a new strain of flu could invoke new government powers.

Once a public health emergency is declared, the legislation allows state health officials to commandeer health care facilities and medical supplies. This is a slippery slope moving Minnesota toward state-mandated health care rationing.

Due Process Eliminated

The Minnesota Emergency Health Powers Act authorizes the state Department of Health to detain individuals in quarantine or isolation for 48 hours without a court order—365 days a year. Once quarantined, freedom could be restricted at least five days: two days before the court order is received and three days before a court hearing must be held with the detainee present.

The quarantine provision provides health officials with ongoing health powers. As the bill is written, quarantine can be used as a tool of coercion: Government officials could threaten quarantine to pressure families into vaccination, examination, treatment, or testing. The legislation does not require that citizens be informed of their right to refuse medical procedures.

A Few Protections

Three protective measures are part of the bill:

- A sunset date assures repeal—or at least reconsideration—of the legislation in August 2004.
- Conferees adopted an amendment, written by Citizens' Council on Health Care, prohibiting state officials from commandeering medical supplies that health care providers consider essential for their continued practice and operation. In addition, medical supplies and medications being used by individuals cannot be confiscated.
- A study of health care rationing, professional immunity, and constitutional issues is required by the bill. The legislature must receive a report by January 15, 2003. However, state health powers will go into effect upon the bill's enactment—long before the study must be completed.

A great grab for power by health officials is underway across the nation. After September 11 and before upcoming elections, Minnesota legislators remain afraid to vote against legislation labeled anti-terrorist. But if the Health Powers Act passes, Minnesota citizens could face more terror at the hands of their own government than from any foreign terrorist.

Twila Brase is president of Citizens' Council on Health Care (CCHC) and a public health nurse. Brase is also a contributing editor to Health Care News *and writes a regular column on health care issues for The Heartland Institute's bimonthly magazine,* Intellectual Ammunition.

Ashcroft Rebuked in Oregon Court

Federal judge stops Department of Justice effort to nullify assisted suicide law

BY CONRAD F. MEIER

According to U.S. District Judge Robert Jones of Portland, Oregon, U.S. Attorney General John Ashcroft is not the nation's health care cop. In an April 17 decision, Jones upheld Oregon's physician-assisted suicide law, ruling the Justice Department "overstepped its authority" in attempting to nullify the law.

Jones issued a permanent injunction preventing the federal government from interfering with the statute. The ruling is critical of Ashcroft, whose November 2001 directive seeking to nullify the law began the legal dispute.

Jones wrote, "To allow an attorney general to determine the legitimacy of a particular medical practice ... would be unprecedented and extraordinary." The federal government, Jones said, is not authorized to "act as a national medical board" and regulate how doctors treat patients.

Jones criticized Ashcroft for his attempts to "stifle an ongoing, earnest, and profound debate in the various states concerning physician-assisted suicide."

"The federal government, [U.S. District Judge Robert] Jones said, is not authorized to 'act as a national medical board' and regulate how doctors treat patients."

Death with Dignity

At issue is Oregon's Death With Dignity Act, approved by voters in 1994 and reaffirmed in 1997. The law—the only one of its kind in the nation—allows physicians to prescribe, but not to administer, a lethal dose of drugs to individuals with less than six months to live. Two doctors must confirm the prognosis.

Between 1997, when the law took effect, and 2001, 141 lethal prescriptions were issued, resulting in 91 physician-assisted suicides, according to state Department of Health records.

Last November, Ashcroft reversed a 1998 Justice Department decision not to pursue legal action against Oregon doctors who complied with the law. He issued a directive saying the prescription of lethal doses of medication

Photo/Susan M. Gaetz-Getty Images

Attorney Eli Stutsman, lead drafter of the Oregon Death With Dignity Act, speaks to the news media following a federal judge's ruling upholding physician-assisted suicide April 17, 2002 in Portland, Oregon. U.S. District Judge Robert Jones said Attorney General John Ashcroft overstepped his authority by trying to frustrate the Oregon law.

served no "legitimate medical purpose," and therefore violated the federal Controlled Substances Act. Ashcroft ordered the Drug Enforcement Administration to target the prescription licenses of doctors who prescribed lethal doses, a move that would have had the effect of nullifying the Oregon law.

Oregon state government officials filed suit, seeking an injunction against the federal government, which Jones granted on April 17.

Plan to Appeal

Assistant Attorney General Robert McCallum said the department remains convinced federal law prohibits the use of controlled substances for use in assisted suicides. "A just and caring society should do its best to assist in coping with the problems that afflict the terminally ill. It should not abandon or assist in killing them," McCallum told *USA Today*.

According to a *Wall Street Journal* report, Justice Department officials said they were likely to appeal the decision. The Oregon law will stand unless a higher court overturns Jones' ruling.

Supporters of physician-assisted suicide applauded the decision. "The ruling respects and secures the right of dying Oregonians to make their own decisions," said Estelle Rogers, executive director of the Death With Dignity National Center. The ruling, according to Rogers, "protects the ability of physicians nationwide to provide adequate and appropriate pain care to their terminally ill patients, without fear that the DEA will second-guess their intent and punish them."

Because Jones did not address whether there is a constitutional right to assisted suicide, supporters say the ruling will almost certainly withstand appeal.

Opponents of physician-assisted suicide disagreed. James Bopp Jr., an attorney for the National Right to Life Committee, said Jones' ruling was not consistent with a Supreme Court decision last year finding sections of California's medical marijuana law violated the Controlled Substances Act. Bopp told the *Los Angeles Times*, "If using marijuana for glaucoma is not permitted by the Supreme Court, under the pretext of medical care, I don't see how killing patients can be justified."

Dr. Greg Hamilton, a spokesperson for Physicians for Compassionate Care, echoed Bopp's sentiments. "Assisted suicide is not a legitimate medical purpose in Oregon or anywhere in the world," he said.

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State Legislative UPDATE

COMPILED AND EDITED BY CONRAD F. MEIER

ALABAMA

Officials at the Centers for Medicare and Medicaid Services (CMS) declined to grant Alabama permission to continue to use the Medicaid upper payment limit, commonly known as the Medicaid loophole, under the state's current formula.

Under the loophole, the state reimburses public hospitals and nurses for care provided to Medicaid beneficiaries at 150 percent of the Medicare rate. The state thus receives additional federal matching dollars. It then requires the facilities to return the extra reimbursements to the state, which can use the money for anything it desires.

According to a report issued a year ago by the Office of Inspector General of the Department of Health and Human Services, the Alabama Medicaid Agency in fiscal year 1998 made unauthorized changes to the way it computed the enhanced payments under the loophole. CMS officials maintain the state owes the agency about $548 million for "duplicate payments, improper leveraging of funds, and accepting federal overpayments," according to Associated Press news reports.

According to CMS spokesperson Peter Ashkenaz, the agency will stop paying Alabama about $2 million annually unless the state increases its financial contribution to the Medicaid program.

ARKANSAS

In response to a $12.8 million cut to the Medicaid program imposed by Gov. Mike Huckabee (R), State Sen. Mike Beebe is seeking support for a plan that restores funding by using the state's tobacco settlement fund. Because Medicaid costs exceeded the funding budgeted for the program last spring, Huckabee ordered the state to make "administrative adjustments," charge copayments, and tighten eligibility standards.

INDIANA

Cuts in Medicaid payments to Indiana nursing homes were halted by a court order. Responding to a budget shortfall for the Medicaid program in this fiscal year, Gov. Frank O'Bannon (D) ordered state officials to cut $660 million from the program by 2003.

Of that amount, state officials planned to cut $120 million from payments to nursing homes. The first phase was to include $22.5 million in cuts, $15.8 million of which have been implemented since October 2001. The Indiana Health Care Association responded by suing the state, alleging the state failed to follow "proper procedures" when making the cuts.

The court agreed and put on hold the remaining $6.7 million in cuts from the first phase. Medicaid Director Melanie Bella said the state plans to "correct the errors in procedure."

LOUISIANA

An audit of the state's Medicaid managed care program, called CommunityCARE, found the system is cutting costs by reducing emergency room visits.

The reports suggests the state needs to do a "better job" of monitoring the program. The state plans by the end of 2003 to have all 500,000 Medicaid beneficiaries in CommunityCARE.

The program now covers about 75,000 beneficiaries who live in rural localities. The state had implemented CommunityCARE to encourage beneficiaries to receive most of their medical care at a doctor's office rather than in an emergency room, where costs are more expensive.

MISSISSIPPI

With the state's Medicaid program facing a $148 million budget shortfall this fiscal year, the state House of Representatives approved a package covering about $120 million of the shortfall. Under the bill, $108 million would be shifted from the state's tobacco settlement fund to Medicaid, and reimbursements and services would be cut to save an additional $50 to $60 million.

The bill also would reduce payments to Medicaid providers by 5 percent. For beneficiaries, prescription drug copayments would increase from $1 to $3; the number of prescriptions covered in a month would drop from 10 to seven; and eyeglass purchases would be limited to every five years instead of three.

OREGON

The Oregon Legislature's interim budget committee on May 1 approved a proposed expansion of the Oregon Health Plan (OHP), the state's Medicaid program, about a week after Gov. John Kitzhaber (D) announced he had given up on altering the program.

Earlier, the legislature's Leadership Commission on Health Care Costs and Trends endorsed the proposal. The approval by the two panels means Oregon officials can send to the federal government a waiver request that, if approved, would allow the state to implement the changes.

Under the bill (HB 2519) lawmakers approved, the current program would be split into two tiers: OHP Plus would cover individuals categorically eligible for traditional Medicaid, and OHP Standard would cover residents who became eligible after the state expanded Medicaid coverage in 1994.

Currently, the Oregon Health Plan allows enrollment by non-Medicaid eligible individuals earning up to 100 percent of the federal poverty level, or $8,860 for an individual. The bill would expand eligibility for non-Medicaid beneficiaries to 185 percent of the poverty level. According to the April 25 edition of the *Kaiser Daily Health Policy Report*, the plan also would require some beneficiaries to contribute copayments for various services, such as $2 for each generic prescription and $250 per hospital admission.

TENNESSEE

Officials of TennCare, Tennessee's troubled Medicaid program, have suspended until July 1 eligibility reverification of enrolled beneficiaries who are categorically ineligible for Medicaid, in order to shift the process from county health departments to the state Department of Human Services. The shift will create a "unified reverification process" at the state health department, which already determines eligibility for Medicaid-eligible TennCare beneficiaries as well as for residents applying for other state assistance programs.

TennCare beneficiaries are required to reverify their

eligibility on an annual basis through in-person interviews. In December 2001, however, the state began "a new round" of eligibility redetermination. Under the court-approved plan, 80,000 people have been found ineligible and dropped from the program. While the verification process is suspended, the state also will have time to hire an additional 227 employees who will work on the process.

TEXAS

To force the state to increase Medicaid payments to nursing homes, two Texas nursing home organizations have joined a lawsuit against the state Department of Health and Human Services.

The Texas Association of Homes and Services for the Aging and the Texas Health Care Association filed a "friend of the court" briefing on January 29 that said the state is not adhering to an agreement reached in 1997 to increase Medicaid reimbursements for nursing homes.

The original lawsuit was filed by the Texas Alliance for Nursing Homes. The nursing homes say they lose $12 per day caring for Medicaid beneficiaries.

WISCONSIN

Uninsured residents would receive discounts on prescription drugs regardless of their age or income under a bill proposed by State Sen. Kim Plache (D) and Rep. Spencer Coggs (D). The measure would allow any resident not enrolled in BadgerCare, the state's Medicaid-expansion CHIP program, or SeniorCare, a state-sponsored prescription drug program for seniors, to receive a "state-determined" discount after paying a $20 enrollment fee.

Plache said the bill, which she will formally introduce after Gov. Scott McCallum's (R) budget amendment is passed, is "intended to give the uninsured the same bargaining clout for lower prescription drug costs" that the insured receive. Pharmacists are opposed to the plan, saying costs associated with such a discount would get passed onto them, not drug makers.

The State Legislative Update is compiled from a wide range of news sources, including the Council for Affordable Health Care (CAHI) the National Association of Health Underwriters (NAHU) ***http://nahu.org****; Bizjournals at* ***http://bizjournals.com****; Stateline at* ***http://stateline.org*** *and Lexis/Nexis research.*

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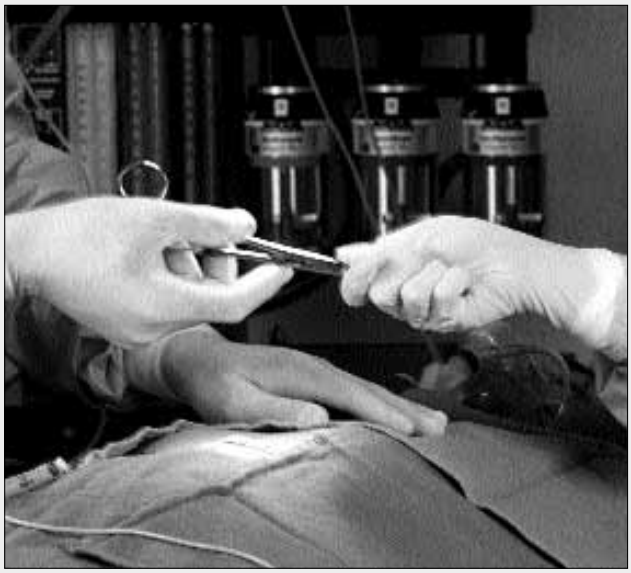
The Galen REPORT



GALEN INSTITUTE

A monthly review of health policy matters

Tax credits are on the front burner again with two new bills.

The first, by Rep. Ernie Fletcher (R-Kentucky), offers $1,000 to individuals and $2,000 to families with incomes up to $35,000 to buy their own health policies or to use toward their costs of a job-based plan.

The Fletcher bill (HR 4170), supported by the Employment Roundtable, provides a 100 percent tax deduction for health insurance for those who don't qualify for the credit and allows rollover of money employees have saved in their flexible spending accounts. A unique feature: It would allow any qualified insurance company offering policies under any one state to sell those policies in every state. This provision is somewhat controversial, but it is designed to set up competition among the states over health insurance mandates and regulation.

Separately, Reps. Kay Granger (R-Texas) and Albert Wynn (D-Maryland) introduced their own tax credit bill (HR 4604) with a refundable tax credit for health insurance, also usable in the workplace. A $1,000 credit is available to individuals earning $65,000 a year, and up to $3,000 for families earning up to $105,000. Associations representing business interests, including the Coalition for Affordable Health Coverage, heartily endorsed this bill, saying the tax credit proposal is good for employers and workers.

Tax credits also are at the center of the debate over the trade bill, which the Senate began debating recently. Both sides are trying to wedge as much of their own agendas as they can into the bill.

Leaders are cutting a deal that would allow some COBRA expansion for health coverage, with federal subsidies of up to 75 percent of the cost, in exchange for some limited tax credits for displaced workers. *However*, workers could use the credits only to buy into existing group plans, like union health plans or state government health programs ... not to shop in the competitive private market.

Labor strongly supports the COBRA subsidies, but management believes (rightly) they could be a camel's-nose-under-the-tent for employer mandates on health insurance.

Ways and Means ranking member Charles Rangel (D-New York) and others proclaimed in a letter that, "Health care is as important as food and shelter," but another Democrat told *CongressDaily* tax credits "are a non-starter."

Tax credits are the best idea to expand health coverage that free-market advocates have proposed in recent memory. The real danger is that supporters will cave in and over-compromise on the issue, condemning it to the same fate as the over-regulated Medical Savings Accounts. Free-market ideas don't work under the constraints of micro-management. It would be better to wait to do it right.

—Grace-Marie Turner

RECENT PUBLICATIONS

Competitive Alternatives to Medicare

Tom Miller
Reason Public Policy Institute
Privatization 2002

The Cato Institute's Tom Miller chronicles recent attempts to expand choice and competition in Medicare through Medicare+Choice and BBA reforms in a new Reason Public Policy Institute report, *Privatization 2002*.

While most of these efforts have hit the shoals of politics, Miller is optimistic that greater privatization can be achieved by moving from a defined benefit structure to a defined contribution/premium-supported model.

"Healthy competition would encourage the [fee-for-service] Medicare program to improve and fight for market share on a level playing field," Miller writes. "Seniors seeking additional supplemental benefits would pay additional premiums reflecting their marginal costs, and their value."

Full text: http://www.rppi.org/apr2002.pdf (pages 13-15 of the pdf document)

A British Warning for American Health Care

Amity Shlaes
The Financial Times, 4/23/02

The announcement that Britain plans to increase taxes to fund health care went largely unnoticed by the U.S. due to our "cultural ambivalence" over health care, reports columnist Amity Shlaes in *The Financial Times*. Britain acknowledges its health care system is in serious trouble, but "America has not yet reached a crisis."

"The difference between 'them' and 'us' is not as great as Americans believe," Shlaes writes. Americans demand more entitlements, which result in more political control over the health care system, increasing to 45 percent the portion of the U.S. health care system financed by government.

Americans face a "budgetary time-bomb [in Medicare and Medicaid] similar to Britain's." Without reform, the two systems will consume the budget, guaranteeing an increase in taxes. The U.S. should recognize the limits of these public programs and offer stronger incentives to the private sector, with ideas like those offered by the Galen Institute.

Full text: http://news.ft.com/ft/gx.cgi/ftc?pagename=View&c=Article&cid=FT3ONWG3E0D&live=true&useoverridetemplate=FTD1OUN2DNC&tagid=FTDNE3BOBNC&SectionTag=na/column&PageTag=2coamsh&imgID=FT32WHWP87C

Do as I Say, Not as I Do: Big Corporations' Quest to Limit Drug Advertising

Dr. Merrill Matthews Jr.
Institute for Policy Innovation, 4/2/02

The proliferation of direct-to-consumer (DTC) drug advertising is beneficial because it serves patient demand for information about their medical conditions, says Merrill Matthews of the Institute for Policy Innovation. "The U.S. health care system is transitioning from a physician-directed system to a patient-directed one. ... It's the demand for information that is driving this transition." Matthews writes.

Nonetheless, several major corporations have formed a coalition called Business for Affordable Medicine to fight DTC advertising. Matthews points out that General Motors and Wal-Mart, two members of the coalition, spend billions of dollars a year on their companies' advertising campaigns. He argues these companies would never stand for limits on the advertising of their products, but they are more than happy to restrict drug industry ads because they have a financial incentive to do so through savings in employer-paid health care.

Full text of the article: http://www.ipi.org/ipi/IPIPublications.nsf/PublicationLookupFull%20Text/F8F22940A449F71086256BA0007287F1

Ex-FDA Chief Recants on Drug Advertising

Raja Mishra
Boston Globe, 4/17/02

Former FDA Commissioner David Kessler recently told a convention of drug and advertising executives he was wrong in leading a seven-year effort to prevent the pharmaceutical industry from promoting drugs directly to consumers, reports the *Boston Globe*.

Kessler, now dean of the Yale University School of Medicine, said, "On the whole, I think there is a lot of educational benefit," citing a 2001 Kaiser Family Foundation study showing direct advertising has increased consumer understanding about drugs, their side effects, and the conditions they treat.

Kessler's admission comes on the heels of AARP announcing a $10 million advertising campaign, partly to counteract direct-to-consumer pharmaceutical advertising. What are the AARP leaders thinking? They will be spending their members' money on a campaign designed to provide seniors with less information about new therapies that could enhance and even save their lives. Doesn't sound like a very good plan, especially in light of Kessler's remarks.

Full text available for a fee at: http://www.boston.com

Material for this report is provided by The Galen Institute, P.O. Box 19080, Alexandria, VA 22320, http://www.galen.org. *Grace-Marie Turner is president. This report is produced by Elizabeth Lamirand, who can be reached at 703/299-9550, and edited by Conrad F. Meier, managing editor of* Health Care News.

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My TURN

BY CONRAD MEIER - MANAGING EDITOR

Health Insurance Heartburn

Our health care system has a very bad case of regulatory indigestion. After years of an indulgent regulatory diet cooked up in both Democratic and Republican kitchens, health insurance heartburn is rising faster than you can say "pass the Rolaids."

It's the Diet, Dummy

From 1988 to 1996 we were headed in the right direction. During those years of "lite" regulatory intervention of the health care free market, there was a steady decline in premium inflation to a low of 0.8 percent. (See accompanying figure.)

Even with HillaryCare scratched from the menu, a great deal of regulatory food was left on the table. Health care statists had a feeding frenzy on leftover socialized medicine regulations and created an indigestible recipe called the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As the graph indicates, following the modest inflation rate of 0.8 percent in premium cost, the expensive regulations in HIPAA started to work their way though the entire health care economy.

Causes of Health Care Heartburn

Excessive government mandates and overbearing regulations play a major role in driving up health costs, according to a PricewaterhouseCoopers (PwC) study released in May by the American Association of Health Plans.

Projecting an overall premium increase of 13.7 percent for 2002, PwC attributes 15 percent of that increase to government mandates and regulations, 7 percent to litigation, and 5 percent to fraud and abuse. Taken together, regulations, litigation, and abuse thus account for 27 percent of the increase in health care costs in this country, more than any other factor. Other factors included new technologies like drugs and medical devices (22 percent), rising hospital expenses (18 percent), general inflation (18 percent), and increased consumer demand (15 percent).

> **"It's time to stop the nonsense inherent with politically driven health care and make the move to consumer-driven health care."**

More than 1,500 mandated benefit laws have been passed since 1970. "Each mandate adds its own cost, and collectively they have significantly increased health care costs," concludes the PwC study. HIPAA alone will add billions of dollars in new compliance costs; if a federal patients' bill of rights passes with significant expansion of health plan liability, health insurance premium costs will increase over the current highs.

As I write, state and federal health care chefs are mixing up more regulatory recipes that go beyond legitimate consumer protection. They offer pure political micromanagement ... and none of these proposals has been subjected to any serious cost analysis or market impact.

Chef Tom Daschle (D-South Dakota) added an amendment to the Fast-Track Trade Bill that includes unprecedented federal health care benefits for workers who lose their jobs as a result of free-trade pacts. Further, the amendment would provide one year of health care benefits for retired steel workers who lost health insurance as a result of recent bankruptcies. The Democrats' own estimate of this spicy bit of inflationary legislation is $400 million.

Even worse (if that is possible), it is fair to suggest Democrats will later try to expand the program to include other unemployed people or employees whose employers do not provide health insurance.

Heartburn Rx

The political health care agenda should be about expanding access. Instead it's about more regulation, more mandates, and more costly micromanagement of a system showing severe gastric distress.

There are two popular schools of thought about the best solution to the problems caused by legislators:

- Some believe in a single-payer system, insisting the only way to get real control is through a complete government takeover of all matters health care. Look at the *Health Care News* series on health care in Britain to see where that philosophy will take us.
- Then there are those of us who believe in a system that engages the power of consumers to force efficiencies in the health sector by demanding the best value for their money. This is not brain surgery. It is common sense, proven daily in other properly functioning sectors of the free market. This, by definition, rules out the central command-and-control model used in Medicare and Medicaid.

It's time to stop the nonsense inherent with politically driven health care and make the move to consumer-driven health care. Specifically, we need to embrace Medical Savings Accounts, defined contribution plans, SimpleCare, high-risk insurance pools, and tax credits for health care-related insurance premiums. We need to move away from third-party payments where possible, expand the use of mandate-free insurance policies, and privatize Medicare and Medicaid.

And until we reach those lofty goals ... pass the Rolaids.

For more information…

WWW The full text of the May 2002 PricewaterhouseCoopers study is available on the Internet at Full study: **http://www.aahp.org/InternalLinks/PwCFinalReport.pdf**.

Conrad F. Meier's series on British health care, "Health Care in England: Not Your Cup of Tea," ran in the September and December 2001, and the March, April, and May 2002 issues of *Health Care News*. All are available on The Heartland Institute's Web site at **www.heartland.org**.

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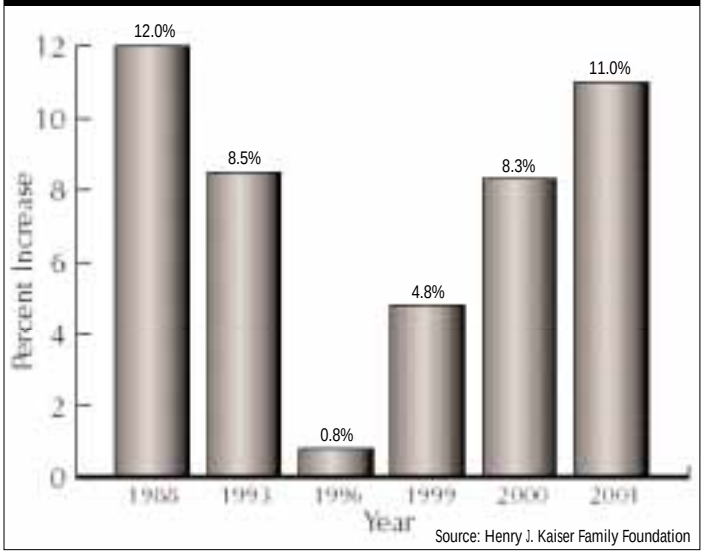
Health Care Inflation, 1998 - 2001



Source: Henry J. Kaiser Family Foundation

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Wednesday, September 18
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